

comprehensive literature review, with expert panel judgment, informed the selection of criteria (and their relative weighting) for the pharmacotherapeutic evaluation. The resultant scoring system was circulated (in questionnaire format) to prescribers and stakeholders for comment. Based on statistical analysis of the latter survey results, the final scoring system was developed. Drug entities which exceeded the evidence threshold score were entered into a tendering process with pharmaceutical suppliers. Product lines submitted as a result of the tendering process were sequentially entered into the second and third phases of the STEPS process (safety/risk assessment; budget impact analysis). **RESULTS:** Three drug entities (from the 5 currently available in the UK) exceeded the evidence threshold and 29 from 39 submitted product lines, containing these drug entities, satisfied the safety evaluation/risk assessment criteria. Two product lines, each containing a different drug entity, were selected for formula inclusion as a result of the budget impact analysis. The estimated annual cost savings for statins as a result of this selection process (based on estimated annual usage in Defined Daily Doses) in this health board, was 40%. **CONCLUSION:** The STEPS model has a significant contribution to make in containing statin costs while retaining the most therapeutically appropriate agents.

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COST SAVINGS ASSOCIATED WITH TABLET SPLITTING PROGRAM IN A PHARMACY BENEFIT MANAGEMENT SETTING

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OBJECTIVES: The purpose of the study is to evaluate the impact of a tablet splitting program in a large pharmacy benefit management organization on the costs and utilization of prescription drugs. **METHODS:** Using a retrospective cohort study design, prescription records from January 1, 2005 to June 30, 2005 were obtained from a pharmacy claims database. Three study cohorts—voluntary, mandatory, and control cohort were created based on the enrollment status in the tablet splitting program. The number of prescriptions dispensed, the total costs and savings per prescription were analyzed and compared for the study drugs Lexapro, Lipitor, and Zoloft. **RESULTS:** A total of 606,068 prescriptions, 594,825 in the control, 5226 in the mandatory and 6017 in the voluntary cohort were included. Total cost savings were obtained by subtracting the difference in cost/days supply between drugs in the control group and each active treatment group. Total cost savings are at \$179,575.85 and \$74,119.53 for the mandatory and the voluntary cohort respectively after adjusting for the operation costs and subtracting the costs from the treatment cohorts. An average per prescription cost saving of \$34.36 for the mandatory and \$12.31 for the voluntary program was realized for the three drugs studied. **CONCLUSIONS:** A tablet splitting program has been shown to produce significant savings, \$34.36 and \$12.31 per prescription for the health plan enrolled in the mandatory and voluntary programs respectively.

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ISPOR CONTRIBUTED RESEARCH 1998–2005: EVALUATION OF TRENDS & QUALITY INDICATORS

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OBJECTIVES: The purpose of this study was to perform a longitudinal content analysis to assess trends in contributed research papers presented at ISPOR Annual Meetings and European Con-

gresses from 1998 through 2005 as available in the ISPOR Research Digest at www.ispor.org, as well as to assess research quality indicators. **METHODS:** The database of 5852 contributed presentations at the ISPOR meetings from 1998 through 2005 were analyzed for trends and quality indicators. Trends were evaluated for outcomes assessed (clinical, economic, patient-reported outcomes), and types of health policy and diseases studied. Quality indicators were defined as abstracts including “study perspective”, “discounting”, or “statistical considerations” (“confidence interval”, “standard deviation”, “mean/median”, “sensitivity analysis”). **RESULTS:** ISPOR held 16 international meetings during 1998–2005. The annual number of contributed research presentations increased from 270 to 1248 for an eight-year total of 5852 with all topics and disease categories increasing over time. The major topic areas covered were cost (42%), patient-reported outcomes including methods (23%), health policy (23%), methods and concepts (10%), and clinical outcomes evaluations (6.4%). The top four diseases (4992 disease-specified papers) were neurological/mental health (18.5%), cardiovascular (17%), cancer (9%), and infectious diseases (10%). With respect to quality indicators, a study perspective was mentioned in 18% (37% cost studies, & all others ~4% each); discounting in 8% (16% cost studies & all others <2% each). For statistical considerations, the percent mentioning mean, median, standard-deviation, confidence intervals, or sensitivity analysis (12%), was 41%. Overall, the percent of abstracts with these quality indicators generally increased over the study period. **CONCLUSION:** The number of papers has increased over the study period for multiple topics and diseases. Although the general quality of papers, as considered in this analysis, was increasing, the percent of papers that include these quality indicators needs further evaluation & improvement.

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CALCULATION OF LORENZ CONCENTRATION CURVES AND GINI COEFFICIENT OF HEALTH EXPENDITURES IN HUNGARY

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OBJECTIVE: The aim of the study to calculate the Lorenz concentration curves and Gini coefficient of health expenditures in Hungary. **METHODS:** Data derived from the financial database of the Hungarian National Health Insurance Fund Administration, covering the period 2000–2004. The Hungarian health care financing system based on a regular patient level data reporting system which allows us to calculate the cumulative frequency distributions of health expenditures. In each type of care we put the patients into 100 percentile group ranked by the health expenditures. **RESULTS:** The top quadrant (top 25%) of the patients (with highest health expenditures) received different portion of health expenditures (2004): 72.4% in out-patient care, 64.1% in in-patient care, 67.3% in chronic care, 56.3% in CT/MRI examinations, 56.2% in home care, 46.1% in renal dialysis, 83.8% in drug reimbursement, 83.6% in medical devices reimbursement. The visual Lorenz curves are presented for each type of care mentioned earlier and for the five years between 2000–2004. There was not any significant time trend within the same type of care. We found the following Gini coefficients (2004): out-patient care: 0.6352, in-patient care: 0.5278, chronic care: 0.5624, CT/MRI examinations: 0.4459, home care: 0.4319, renal dialysis: 0.4251, drug reimbursement: 0.7444, medical devices reimbursement: 0.7480. We found significant